



## Director-General's Review

### Distribution of human resources

The Department impacts directly on resource flows to provincial health services through the central allocation of interns, the Community Service Programme for doctors, dentists and pharmacists and the placement of foreign doctors working in South Africa under government-to-government agreements.

The number of professional health workers involved is quite substantial (see table) and a serious attempt is made to place as many as possible in poorly served areas.

The result may not be perfect but it is powerfully positive. For instance: In the Northern Cape the number of full-time doctors improved from 20 in 1994 to 111 in 2000. The Eastern Cape was able to place pharmacists in hospitals that had been without any for a long period. Even the doctor-rich Western Cape reported that community service doctors filled a gap in day hospitals in areas where they battled to attract professionals.

Constraints on a more rigorously equitable approach to placing these professionals included: The limited availability of funded posts in some provinces; the placement preferences of candidates; suitable supervision mechanisms; and suitably equipped facilities, especially for dentists.

### Access to affordable medicines

The price of medicines is a critical factor in determining access to appropriate treatment. In the public sector certain drugs that would be the first-line medication for various conditions are not affordable. In addition, the high price of medicines often puts private health care beyond the pocket of individuals who would otherwise purchase health care.

In 1997 Parliament enacted the Medicines and Related Substances Control Amendment Act

### Allocation of community service professionals in 2000/2001

PROVINCE	DOCTORS	DENTISTS	PHARMACISTS
EC	149	15	33
FS	79	10	39
GP	126	12	68
KZN	271	32	82
MP	107	25	39
NC	34	8	5
NP	150	15	33
NW	97	26	31
SAMHS	40	11	14
DCS	N/A	N/A	14
WC	141	10	48
SA	1194	164	406

that provided a number of mechanisms to reduce the cost of medicines and promote their rational utilisation.

For instance, it facilitated the purchase of patented drugs at the cheapest international price (whereas presently the local price simply has to be accepted); it set in place a Ministerial Pricing Committee to establish transparent drug pricing procedures; and it obliged pharmacists to offer clients the cheapest available version of a drug with an equivalent therapeutic effect, where both the brand name and legal generic versions were on the market.

Months after enactment, the Medicines Control Amendment Act was challenged in court by 39 multinational drug companies under the umbrella of the Pharmaceutical Manufacturers Association of South Africa. The court action, which effectively paralysed the Act for three years, came to a head in the closing months of 2000/1.

The hearing, scheduled to take place in the Pretoria High Court in March 2001, became the focus of an unprecedented tide of international protest against the pricing practices of the multinational pharmaceutical giants.

Three years earlier the South African Government had attracted suspicion rather than support when it asserted its right to secure affordable medicines in order to fulfill its constitutional duty of ensuring access to health care. However, we did not deviate from the principled defence of this position and witnessed nothing less than a revolution in public sentiment in 2001, as many governments as well as popular organisations adopted the cause of affordable medicines.

In April 2001, in the glare of international media attention, the pharmaceutical industry abandoned its court action against the South African Government. Very importantly, the Medicines Control Amendment Act was set free for implementation. Equally importantly:

- The South African Government's argument that the Act did not conflict with its international obligations to respect intellectual property rights was recognised as legitimate.
- Opportunities for engaging the pharmaceutical industry on a different footing opened up, with the possibilities of new forms of partnership.

Our National Drug Policy, like that of any country, is multifaceted. We continue to improve overall pharmaceutical management and in particular:

- To support implementation of the Essential Drugs Lists and Standard Treatment Guidelines.
- To improve the reliability of our distribution networks to ensure that the right drugs are available at the right place in the right quantities.
- To address drug theft. The Department has established a joint task team with the pharmaceutical industry to tackle this problem. It is now a requirement that all drugs supplied on tender must be labelled: "For State use only. Not for sale".

### Private sector provision

The most pronounced inequities in health care provision remain the differences between private and public sector provision. The private sector, servicing some 20% of the population, absorbs 60% of all health spending. The high cost of care in the private sector drives individuals who should be able to purchase health services to rely on free or subsidised care in the public sector. Equity can be served by containing private health care costs, thus retaining clients in that system, and by recovering costs in the public sector when patients can afford to pay.



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The price of medicines, long identified as a central cost-driver in the regular rise of medical scheme contributions, will now be addressed through the Medicines Control Amendment Act.

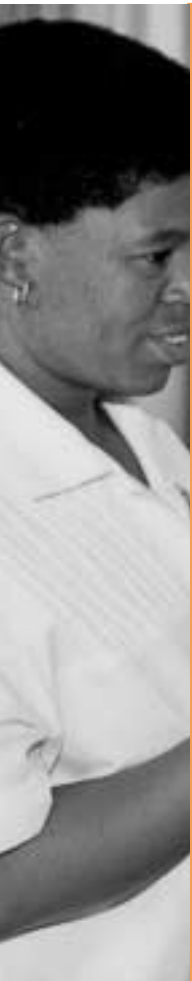
In addition, access to medical schemes has been improved through the Medical Schemes Act of 1998 that outlawed the dumping of members in old age and the barring of members on various grounds, including a pre-existing health condition.

Several critical aspects of the Act only came into effect on 1 April 2000, so it would be premature to make a definitive assessment of its impact on access to care and equity. It is, however, fair to say that predictions that the law would have deleterious effects on the medical schemes industry have not materialised. We believe that regulatory oversight by the Council for Medical Schemes has improved and we need to build on these achievements to make schemes more accountable to members.

## Quality of care

During 2000/1 initiatives on quality of care centred on the Patients' Rights Charter that was promoted widely among health workers and service users in every province.

However, there are many other perspectives on quality in health care provision.



## Quality of care

### What provinces are doing

#### Eastern Cape

- Has accredited 19 hospitals with COHSASA\*
- Is using retired specialists to assist in district services
- Has formed hospital boards at some facilities

#### Free State

- Established a provincial Quality Assurance Unit
- Investigates all "unusual incidents" each month
- Has accredited 12 hospitals with COHSASA

#### Gauteng

- Recognised service excellence through its Khanyisa Awards
- Reinforced the Charter with a Pledge of Service
- Has an Accreditation

Committee to monitor service standards

#### KwaZulu-Natal

- Got COHSASA's help with peer reviews and clinical audits
- Appointed an ombud to seek feedback and deal with complaints
- Set a 100% target for hospital boards and clinic committees

#### Mpumalanga

- Set up a team to conduct quality of care assessments
- Tabled Health Facilities & Services Bill dealing with governance
- Established peer review committees in hospitals

#### Northern Cape

- Appointed a full-time ombud to handle complaints
- Did extensive training on Batho Pele approach
- Developed a tool to measure quality issues in clinics

#### Northern Province

- Instituted monthly mortality and morbidity meetings
- Installed suggestion boxes and monitored inputs weekly
- Created a provincial Clinical Guidelines Committee

#### North-West

- Instituted peer review in relation to patient mortality
- Did client satisfaction surveys in 30% of hospitals
- Supported its workers through employee support programmes

#### Western Cape

- Established a service help line
- Drafted a Health Facilities Boards Bill
- Budgeted R3-million to improve waiting areas

\*Council for Health Services Accreditation of Southern Africa



Significant among these is the effectiveness of treatment or, put differently, the quality of clinical care.

As the responsibility for popularising the Charter passed into the hands of provincial and district health services, the Department began to focus its attention on developing a more comprehensive quality framework to guide further developments (See Page 38). In March 2001, the Minister of Health and provincial MECs approved the framework.

Partnerships proved critical to the Patients' Charter campaign, with buy-in from the provincial and local health authorities being the key success factor. Endorsement by MECs for Health and local councillors underscored the legitimacy of this patient-centred strategy, while civil society structures built awareness in communities. The National Progressive Primary Health Care Network that pioneered the Health Rights are Human Rights campaign in the mid-90s provided invaluable advice.

However, problems in relation to quality of care are persistent and complex. An erosion of the professional ethos is frequently identified as the key issue — and this is possibly true. However, other important contributory factors are poor management of services, inadequate knowledge and skills and, sometimes, resource constraints. The quality framework addresses all these dimensions. Its implementation will demand a range of new partnerships, including the trade unions, professional associations and statutory councils for various professions.

## Preventing illness and promoting health

Gains in the health status of the population - reflected in lower mortality rates and increased longevity — are largely (but not entirely) secured by interventions that take place outside hospitals and clinics: By improvements in general living conditions, by individuals adopting certain lifestyles and habits and by laws that shape our behaviour in relation to health.

The health sector clearly has a critical role to play in terms of creating public awareness, improving health literacy, sponsoring the kinds of laws that safeguard health and life. In addition to this, there are specific health services that make a critical difference. For instance: Immunisation programmes and strategies for early detection and treatment of potentially fatal conditions.

A range of preventive and promotive programmes has been designed and implemented in recent years and their progress is reviewed in Section 2 (Pages 21 to 53). This summary merely highlights some achievements and difficulties. Success seldom rests on a single mode of intervention: In almost all cases the problem is tackled from several angles simultaneously.

The Expanded Programme of Immunisation has succeeded in keeping polio absent from this country (although it is still endemic in several African countries); and in sharply reducing the incidence of measles in the last three years. Hib vaccine, introduced two years ago, is now established as the seventh element in our standard vaccination regimen. We should soon see the benefit in the pattern of deaths in children under five years.

The Tobacco Products Control Act became effective in 2000/1. By the end of the year the ban on tobacco product advertising and sponsorship of events by tobacco manufacturers was fully in force. Smoking in public places and work places was restricted to specific smoking areas. Tighter controls will go hand-in-hand with education campaigns aimed at pre-adolescents and adolescents. Research on attitudes and smoking practices among young people was completed during the year by the Medical Research Council and this will inform the development of educational programmes.

The re-emergence of malaria as a major cause of illness and death in three provinces has prompted us to revisit our strategies for control and management of the disease. In 2000/1 we negotiated the re-introduction of DDT spraying under strictly controlled conditions. A new drug has been acquired

